

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0044792</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Villa Scalabrini Nursing & Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/00</u> to <u>6/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>480 N. Wolf Road</u> <u>Northlake</u> <u>60164</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(708) 562-0040</u> Fax # <u>(708) 562-3955</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u> (Date) _____	
IDPA ID Number: <u>23-7061646008</u>		(Print Name and Title) <u>Richard Sgarlata, CPA</u>	
Date of Initial License for Current Owners: <u>3/1/00</u>		(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Road, Suite 300, Deerfield, IL 60015</u>	
Type of Ownership:		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____			
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u>			

Facility Name & ID Number Villa Scalabrini Nursing & Rehab# 0044792 Report Period Beginning: 07/01/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>144</u>	Skilled (SNF)	<u>144</u>	<u>52,560</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>82</u>	Intermediate (ICF)	<u>82</u>	<u>29,930</u>	3
4		Intermediate/DD			4
5	<u>33</u>	Sheltered Care (SC)	<u>33</u>	<u>12,045</u>	5
6		ICF/DD 16 or Less			6
7	<u>259</u>	TOTALS	<u>259</u>	<u>94,535</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,123</u>	<u>9,410</u>	<u>3,032</u>	<u>30,565</u>	8
9	SNF/PED					9
10	ICF	<u>28,882</u>	<u>17,509</u>		<u>46,391</u>	10
11	ICF/DD					11
12	SC	<u>1,882</u>	<u>7,301</u>		<u>9,183</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>48,887</u>	<u>34,220</u>	<u>3,032</u>	<u>86,139</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.12%

D. How many bed-hold days during this year were paid by Public Aid?

523 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/1/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/1/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 13 and days of care provided 3,032Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/00

Ending:

6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	541,003	52,883		593,886		593,886	(745)	593,141		1
2	Food Purchase		469,513		469,513		469,513		469,513		2
3	Housekeeping	330,425	58,473	4,340	393,238		393,238		393,238		3
4	Laundry	160,375	28,133		188,508		188,508		188,508		4
5	Heat and Other Utilities			282,441	282,441		282,441		282,441		5
6	Maintenance	235,981	16,087	137,974	390,042		390,042	(19,694)	370,348		6
7	Other (specify):*										7
8	TOTAL General Services	1,267,784	625,089	424,755	2,317,628		2,317,628	(20,439)	2,297,189		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	3,646,823	230,288	319,593	4,196,704		4,196,704	3,869	4,200,573		10
10a	Therapy	145,187	1,157	794	147,138		147,138		147,138		10a
11	Activities	134,968	4,996	9,116	149,080		149,080	(500)	148,580		11
12	Social Services	306,335	6,116	5,021	317,472		317,472		317,472		12
13	Nurse Aide Training										13
14	Program Transportation			189	189		189		189		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,233,313	242,557	352,713	4,828,583		4,828,583	3,369	4,831,952		16
	C. General Administration										
17	Administrative	75,925		424,451	500,376		500,376	(424,451)	75,925		17
18	Directors Fees										18
19	Professional Services			13,184	13,184		13,184	235,215	248,399		19
20	Dues, Fees, Subscriptions & Promotions			12,602	12,602		12,602	(1,385)	11,217		20
21	Clerical & General Office Expenses	327,329	40,038	51,825	419,192		419,192	316,210	735,402		21
22	Employee Benefits & Payroll Taxes			1,453,301	1,453,301		1,453,301	73,319	1,526,620		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,642	3,642		3,642	(250)	3,392		24
25	Other Admin. Staff Transportation			1,253	1,253		1,253	(450)	803		25
26	Insurance-Prop.Liab.Malpractice			161,827	161,827		161,827		161,827		26
27	Other (specify):*										27
28	TOTAL General Administration	403,254	40,038	2,122,085	2,565,377		2,565,377	198,208	2,763,585		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,904,351	907,684	2,899,553	9,711,588		9,711,588	181,138	9,892,726		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Villa Scalabrini Nursing & Rehab

#0044792

Report Period Beginning:

07/01/00

Ending:

6/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			651,609	651,609		651,609	15,618	667,227			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,929	2,929		2,929	(2,929)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,512	12,512		12,512		12,512			35
36	Other (specify):*			15,600	15,600		15,600		15,600			36
37	TOTAL Ownership			682,650	682,650		682,650	12,689	695,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	19,637	125,556	66,132	211,325		211,325		211,325			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,735	123,735		123,735		123,735			42
43	Other (specify):*	64,545		20,919	85,464		85,464	(85,464)				43
44	TOTAL Special Cost Centers	84,182	125,556	210,786	420,524		420,524	(85,464)	335,060			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,988,533	1,033,240	3,792,989	10,814,762		10,814,762	108,363	10,923,125			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning: 07/01/00

Ending: 6/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(745)	1		4
5	Telephone, TV & Radio in Resident Rooms	(146)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	271	30		9
10	Interest and Other Investment Income	(2,929)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(111,135)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,684)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	223,047		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 223,047		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 108,363		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Villa Scalabrini Nursing & Rehab

ID# 0044792

Report Period Beginning: 07/01/00

Ending: 6/30/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fee	\$ (50)	21	1
2	Collection	(54)	21	2
3	Donation	(50)	20	3
4	Marketing	(1,335)	20	4
5	Community Relations	(20,919)	43	5
6	Jury Duty Income	(200)	21	6
7	Cable Television Expense	(16,145)	6	7
8	Activities Income	(500)	11	8
9	Capitalized R&M	(6,637)	6	9
10	Transportation Revenue	(450)	25	10
11	Community Relations Salary	(64,545)	43	11
12	Out of Period Seminars	(250)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(111,135)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/00

Ending:

6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(745)	0	0	0	0	0	0	0	0	0	0	(745)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(22,782)	3,088	0	0	0	0	0	0	0	0	0	(19,694)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,527)	3,088	0	0	0	0	0	0	0	0	0	(20,439)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,869	0	0	0	0	0	0	0	0	0	3,869	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(500)	0	0	0	0	0	0	0	0	0	0	(500)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(500)	3,869	0	0	0	0	0	0	0	0	0	3,369	16
	C. General Administration													
17	Administrative	0	(424,451)	0	0	0	0	0	0	0	0	0	(424,451)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	235,215	0	0	0	0	0	0	0	0	0	235,215	19
20	Fees, Subscriptions & Promotions	(1,385)	0	0	0	0	0	0	0	0	0	0	(1,385)	20
21	Clerical & General Office Expenses	(450)	316,660	0	0	0	0	0	0	0	0	0	316,210	21
22	Employee Benefits & Payroll Taxes	0	73,319	0	0	0	0	0	0	0	0	0	73,319	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(250)	0	0	0	0	0	0	0	0	0	0	(250)	24
25	Other Admin. Staff Transportation	(450)	0	0	0	0	0	0	0	0	0	0	(450)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(2,535)	200,743	0	0	0	0	0	0	0	0	0	198,208	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,562)	207,700	0	0	0	0	0	0	0	0	0	181,138	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Villa Scalabrini Nursing & Rehab# 0044792

Report Period Beginning:

07/01/00

Ending:

6/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100%	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Salary	\$	Resurrection Health Care		\$ 257,859	\$ 257,859	1
2	V	22 Employee Benefits		Resurrection Health Care		73,319	73,319	2
3	V	19 Data Processing		Resurrection Health Care		200,944	200,944	3
4	V	19 Purchasing		Resurrection Health Care		34,271	34,271	4
5	V	6 Operation of Plant		Resurrection Health Care		3,088	3,088	5
6	V	10 Nursing Admin.		Resurrection Health Care		3,869	3,869	6
7	V	21 Miscellaneous A&G		Resurrection Health Care		58,801	58,801	7
8	V	30 Capital		Resurrection Health Care		15,347	15,347	8
9	V							9
10	V	17 Intercompany Contracted Service	424,451				(424,451)	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 424,451			\$ 647,498	\$ * 223,047	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/00 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Resurrection HC/Medical Center
 Street Address 7435 W. Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21 Salary				\$	\$		\$ 257,859	1
2	22 Employee Benefits							73,319	2
3	19 Data Processing							200,944	3
4	19 Purchasing							34,271	4
5	6 Operation of Plant							3,088	5
6	10 Nursing Administration							3,869	6
7	21 Miscellaneous A&G							58,801	7
8	30 Capital							15,347	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 647,498	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Ameritech		X				\$	\$			\$	2,929	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$	2,929	9
	B. Non-Facility Related*												
10	Interest Income											(2,929)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	(2,929)	14
15	TOTALS (line 9+line14)						\$	\$			\$		15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Scalabrini Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 195,174

B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel/Concrete
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 78,000

2. Number of Years Over Which it is Being Amortized:
 5 Years

3. Current Period Amortization:
 15,600

4. Dates Incurred:
 3/1/00

Nature of Costs:
 Organization Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	696,960	2000	\$ 1,500,000	1
2					2
3	TOTALS	696,960		\$ 1,500,000	3

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/00

Ending:

6/30/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$ 7,510,695	\$ 252,512	35	\$ 252,512		\$ 391,153	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Illuminated Display Sign	8/28/2000		9,374	469	20	469		469	9
10		Redecorating	1/26/2001		6,181	310	20	310		310	10
11		Sign	3/21/2001		6,805	340	20	340		340	11
12		Roof Repair	5/11/2001		4,246	212	20	212		212	12
13		Condenser	8/21/2000		2,185		20	109	109	109	13
14		Monitoring System	8/14/2000		1,592		20	80	80	80	14
15		Refrigeration Service	1/4/2001		1,650		20	82	82	82	15
16											16
17											17
18											18
19		Allocation from Resurrection Health Care				15,347		15,347			19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 7,542,728	\$ 269,190		\$ 269,461	\$ 271	\$ 392,755		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,919,280	\$ 393,896	\$ 393,896	\$		\$ 583,754	71
72	Current Year Purchases	38,703	3,870	3,870			3,870	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,957,983	\$ 397,766	\$ 397,766	\$		\$ 587,624	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,000,711	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 666,956	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 667,227	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 271	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 980,379	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 12,513 Description: Copiers \$12,506; Gas Tech \$7

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
					1	Licensed Occupational Therapist	39-3	hrs	\$		\$	46,937
2	Licensed Speech and Language Development Therapist	39-3	hrs				6,696				6,696	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-1,3	hrs	19,637			12,499				32,136	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescrpts					42,469			42,469	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify): See Supplemental Schedule						83,087				83,087	13
14	TOTAL			\$ 19,637		\$ 66,132	\$ 125,556		\$ 211,325		14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 918,904	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,540,281		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,936		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	52,290		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,535,411	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	7,534,051		14
15	Leasehold Improvements, at Historical Cost	3,250		15
16	Equipment, at Historical Cost	1,922,577		16
17	Accumulated Depreciation (book methods)	(846,984)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,800)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	297,647		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,467,741	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,003,152	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 209,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	198,545		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,423,531		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,831,758	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,831,758	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,171,394	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,003,152	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,638,178	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,638,178	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(466,784)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (466,784)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,171,394	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 12,639,592	1
2	Discounts and Allowances for all Levels	(2,804,590)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,835,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	292,222	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 292,222	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	745	14
15	Telephone, Television and Radio	146	15
16	Rental of Facility Space		16
17	Sale of Drugs	55,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37	19
20	Radiology and X-Ray		20
21	Other Medical Services	100,806	21
22	Laundry	38,415	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 196,051	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,622	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,081	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,081	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,347,978	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,317,628	31
32	Health Care	4,828,583	32
33	General Administration	2,629,922	33
	B. Capital Expense		
34	Ownership	682,650	34
	C. Ancillary Expense		
35	Special Cost Centers	232,244	35
36	Provider Participation Fee	123,735	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,814,762	40
41	Income before Income Taxes (line 30 minus line 40)**	(466,784)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (466,784)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab# 0044792Report Period Beginning: 07/01/00Ending: 6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	384	398	\$ 12,851	\$ 32.29	1
2	Assistant Director of Nursing	2,976	3,571	78,345	21.94	2
3	Registered Nurses	51,084	60,962	1,306,099	21.42	3
4	Licensed Practical Nurses	21,996	24,794	469,027	18.92	4
5	Nurse Aides & Orderlies	162,044	179,402	1,718,924	9.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	655	776	19,637	25.31	7
8	Rehab/Therapy Aides	9,948	11,405	145,187	12.73	8
9	Activity Director					9
10	Activity Assistants	13,497	14,973	134,968	9.01	10
11	Social Service Workers	15,879	16,541	306,335	18.52	11
12	Dietician	1,928	2,414	47,885	19.84	12
13	Food Service Supervisor	5,259	5,577	85,827	15.39	13
14	Head Cook	4,854	5,621	65,203	11.60	14
15	Cook Helpers/Assistants	41,101	42,815	342,088	7.99	15
16	Dishwashers					16
17	Maintenance Workers	16,158	16,832	235,981	14.02	17
18	Housekeepers	35,601	37,084	330,425	8.91	18
19	Laundry	17,881	18,627	160,375	8.61	19
20	Administrator	1,268	1,695	75,925	44.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,527	24,507	327,329	13.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,995	4,458	61,577	13.81	31
32	Other Health Care(specify)					32
33	Other(specify)	3,401	3,937	64,545	16.39	33
34	TOTAL (lines 1 - 33)	433,436	476,389	\$ 5,988,533 *	\$ 12.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	Monthly	3,385	10-3	37
38	Nurse Consultant		774	10-3	38
39	Pharmacist Consultant		8,557	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	21	795	10a-3	43
44	Activity Consultant	175	9,116	11-3	44
45	Social Service Consultant	72	3,761	12-3	45
46	Other(specify) <u>Spiritual</u>	24	1,260	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	292	\$ 45,648		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,352	\$ 184,320	10-3	50
51	Licensed Practical Nurses	2,808	99,684	10-3	51
52	Nurse Aides	1,296	22,874	10-3	52
53	TOTAL (lines 50 - 52)	8,456	\$ 306,878		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership %		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions	
Name	Function		Amount	Description	Amount	Description	Amount	Description	Amount		
Judith Perry	Administrator		\$ 75,925	Workers' Compensation Insurance	\$ 83,072	IDPH License Fee	\$				
				Unemployment Compensation Insurance	11,865	Advertising: Employee Recruitment		700			
				FICA Taxes	429,406	Health Care Worker Background Check		42			
				Employee Health Insurance	793,229	(Indicate # of checks performed 3)					
				Employee Meals		Dues & Subscriptions		10,474			
				Illinois Municipal Retirement Fund (IMRF)*		Marketing		1,335			
				Dental/Life Insurance	40,151	Marketing (adjusted out on page 5)		(1,335)			
				Retirement Plan	43,645						
				Group Disability	32,477						
				Employee Assistance	5,304						
				Medical Screening	7,305						
				Other Benefits	6,846	Less: Public Relations Expense	(
				Allocation from Resurrection	73,319	Non-allowable advertising	(
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,925	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,526,619	TOTAL (agree to Sch. V, line 20, col. 8)	\$	11,216			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount			
Resurrection Intercompany Services			\$ 424,451				Out-of-State Travel	\$			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 424,451				In-State Travel				
C. Professional Services											
Vendor/Payee	Type		Amount								
Frost, Ruttenberg & Rothblatt	Accounting		\$ 920								
FR&R Consulting	Consulting		10,114								
Achieve Software Co.	Data Processing		904								
Integrity Group	Computer Consulting		1,246								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 13,184	TOTAL		\$	Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)				
							TOTAL	\$ 3,392			

*** Attach copy of IMRF notifications**

****See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

STATE OF ILLINOIS

0044792

Report Period Beginning:

07/01/00

Ending:

Page 23

6/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - \$5250
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 57,983 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 123,735
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 745
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.